Grants Pass Podiatry

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PODIATRIC PHYSICIANS AND SURGEONS
1227 NE 7th St., Ste. A; Grants Pass, OR 97526
Phone: 541-471-3668 Fax: 541-471-4814

PATIENT REGISTRATION

Patient's Name ______________________ Date ______________

Date of Birth ______________ Gender ☐ M ☐ F Age ______________

Mailing Address ______________ City ______________ State ______ Zip ______

Home Phone ______________ Cell Phone ______________

SS# ______________ Email ______________

Race ______________ Ethnicity ______________ Marital Status ☐ Single ☐ Married

Education ☐ High School ☐ Undergraduate ☐ Masters ☐ Doctorate Field of Study ______________

Employment ☐ Employed ☐ Not employed ☐ Full-time student ☐ Part-time student ☐ Retired

Employer Name ______________ Occupation ______________

Employer Address ______________ City ______________ Work Phone ______________

EMERGENCY CONTACT

Name ______________ Relationship to Patient ______________

Address ______________ City ______________ State ______ Zip ______

Home Phone ______________ Cell Phone ______________

INSURANCE

Primary Insurance Company ______________ Phone ______________

Policy Holder ______________ Patient's Relationship to Policy Holder ______________

Group # ______________ ID # ______________ Co-pay? ______________

Employer of Policy Holder ______________ Employer Phone ______________

Secondary Insurance Company ______________ Phone ______________

Policy Holder ______________ Patient's Relationship to Policy Holder ______________

Group # ______________ ID # ______________ Co-pay? ______________

Employer of Policy Holder ______________ Employer Phone ______________

SIGNATURE

I agree that the above information is correct to the best of my knowledge, and that I have read and understand all of the Grants Pass Podiatry patient privacy and billing procedures.

Patient Signature ______________________ Date______________

OR Signature of Legal Guardian ______________________ Date______________